Foundation Chiropractic

1062 Bear Creek Boulevard Hampton, GA 30228 770-946-0405

CONFIDENTIAL PATIENT INFORMATION

All information you supply is confidential. We comply with all federal privacy standards. If we do not believe your problem will respond favorably, we will refer you to disciplines we believe will help you. In order for us to understand your health problems, please complete this form neatly, accurately and completely. THANK YOU.

Date _____ Home Phone _____Cell Phone_____

Name _____ Age _____Birth Date _____

Address _____City _____ Zip Code _____

E-mail _____ SSN:_____

How did you hear about us? _____

Occupation / Employer _____ Name of Spouse _____

Emergency Contact Name _____ Relationship _____ Phone # _____

Have you consulted a Chiropractor before? Yes / No When? _____

List present concerns or complaints and approximate date they began. **Date:**

Primary _____ _____

Secondary _____ _____

Additional _____ _____

For your primary concern circle all that apply.

Dull Sharp Throbbing Burning Deep Aching

Tingling Stabbing Cramping Numbness Radiating Stiffness

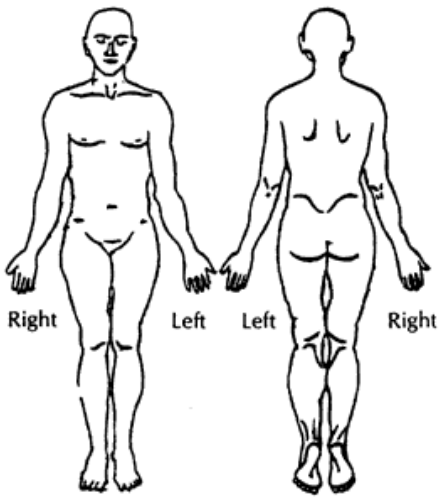
Pain radiates or travels? Yes/No Describe: _____

_____

In your own words describe how and why the problem started: __

_____

Mark Areas of Concern



Which describes the frequency of your concern?

Constant (81 -I00%) Frequent (51-80%) Occasional (26-50%) Comes and Goes (25% or Less)

What is your present general stress level?

No stress Minimal stress Moderate stress High stress

What makes your primary concern worse? _____

Sitting Standing Walking Bending Lifting Sleeping Sneezing Coughing Straining Reaching Twisting
Looking up Looking down Movement Lying Driving Typing Stomach lying House chores Exercise Stairs

What makes your primary concern better? _____

Heat Ice Medication Rest Adjustments Stretching Sitting Standing Lying Knees bent Support
No movement Movement Topical analgesic Ibuprofen Exercise

What is your physical activity at work?

Mostly sitting Light manual labor Moderate manual labor Heavy manual labor

Is your concern affecting your ability to work or do other routine daily activities?

No effect	Have some limited physical restrictions, but can function
Cannot work	Need some assistance with daily activities
Totally disabled	Cannot function without assistance

How does this condition currently interfere with your life and ability to function?

	No Effect	Some Difficulty	Much Difficulty	Unable to Do
Sitting	( )	( )	( )	( )
Rising out of chair	( )	( )	( )	( )
Standing	( )	( )	( )	( )
Walking	( )	( )	( )	( )
Bending over	( )	( )	( )	( )
Lifting objects	( )	( )	( )	( )
Dressing myself	( )	( )	( )	( )
Reaching overhead	( )	( )	( )	( )
Exercising	( )	( )	( )	( )
Household chores	( )	( )	( )	( )
Sleeping	( )	( )	( )	( )
Sexual function	( )	( )	( )	( )
Dressing/grooming	( )	( )	( )	( )
Driving	( )	( )	( )	( )

Other _____

Health History and Symptom Review

A thorough understanding of your heath history is necessary in order to provide the best and most appropriate care. We are a complete wellness center and would like to assist you with any other health concerns you may have along with chiropractic care.

Surgeries you have had: _____

Medications are you taking: _____

Supplements are you currently taking: _____

Have you ever suffered from:

Dizziness	Yes	No	Stroke	Yes	No
Heart trouble	Yes	No	Numbness	Yes	No
Lung Problems	Yes	No	Fainting	Yes	No
Kidney Trouble	Yes	No	Arthritis	Yes	No
Epilepsy	Yes	No	Cancer	Yes	No

Previous serious illness:_____

Dou you currently Suffer from:

Allergies	Yes	No	High Blood Pressure	Yes	No
Cold/Flu	Yes	No	Digestive Disorders	Yes	No
Diabetes	Yes	No	Endometriosis	Yes	No
Migraines	Yes	No	PCOS	Yes	No
Irritable Bowel	Yes	No	Anemia	Yes	No

Additional Symptoms: Please circle 0 as least/never to 3 as the most/always. (Optional Section)

Fatigue	0	1	2	3	Skin irritations	0	1	2	3
Trouble sleeping	0	1	2	3	Depression	0	1	2	3
Digestive issues	0	1	2	3	Anxiety	0	1	2	3
Constipation	0	1	2	3	Brain fog	0	1	2	3
Loose stools	0	1	2	3	Sugar cravings	0	1	2	3
Gas/bloating	0	1	2	3	Frequent urination	0	1	2	3
Frequent belching	0	1	2	3	Hormonal imbalances	0	1	2	3
Acid reflux	0	1	2	3	Mood swings	0	1	2	3
Night sweats	0	1	2	3	Intolerance to smells	0	1	2	3
Heart palpitations	0	1	2	3	Difficulty losing weight	0	1	2	3
Low blood sugar	0	1	2	3	Excessive hair loss	0	1	2	3
					Cold hands and feet	0	1	2	3

What additional heath goals do you have? _____

_____

HIPAA Release

I understand that some of my health information may be used and/or disclosed by Foundation Chiropractic to carry out treatment, payment, or health care operations, and that a complete description of such uses and disclosures may be made available to me in writing. I also understand that I can request a copy of this privacy notice entitled "Our Privacy Policies", and that disclosures of my health information for any other reason must be agreed upon by me in writing. Initial: _____

Health Insurance/Payment Information

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Initial: _____

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: Chiropractors commonly use their hands or a mechanical device in order to restore mobility and function to joints that are not moving or functioning optimally. For many patients, certain therapies or exercises may also be used to maximize healing and pain relief. I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease. Initial: _____

Possible Risks: The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or other treatment, if he/she is aware that such care may cause problems. It is the patient's responsibility to inform the doctor of any known pathological defects, illnesses, or deformities which would not otherwise come to the attention of the doctor. The most common adverse effects are minor and temporary and include stiffness or soreness after the first few days of treatment (similar to starting a new exercise regimen). Other rare but potential complications include muscular strain, fractures of bone, injury to intervertebral discs, nerves or spinal cord, or stroke/cerebrovascular injury (*estimated to be less than 1 in 2 million to 5.8 million cervical manipulations).* Complications from therapies used in addition to your adjustment are rare but may cause skin irritation, burns, soreness, bruising, or other minor complications.

Risks of remaining untreated: Delay of treatment often results in further deterioration of the condition and may lead to chronic pain and disability, or surgery.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. Initial: _____

Patient Name (printed): _____ Date: _____

Patient Signature: _____
(18 and under requires signature of Parent/Guardian)

Relationship to Child _____